Kansas Smallpox Vaccine Reaction Surveillance Form

You are being asked to fill out this form so that we may learn about any reactions or side effects you experience as a result of receiving the smallpox vaccine. You will be asked to fill out this form multiple times, once for every week after your vaccination, until the scab falls off of the vaccination site.

Please return this form to the nurse or attendant when you are finished.

Today's Date: _____ **Which week post-vaccination: 1 2 3 4** *(circle one)* **other:** ____ *(specify)*

Section A: Vaccinee Personal Information

1. Patient Vaccination Number (PVN): _____

2. First Name: _____ **M.I.:** _____ **Last Name:** _____

3. Facility Name: _____ **4. City:** _____

Section B: Symptoms in the last week

5. Has the scab fallen off of the vaccine site yet? No Yes ⇨⇨⇨ **if yes, date scab fell off:** _____

6. Please indicate whether or not you experienced any of the following symptoms *in the last week:* *(circle yes or no for all that apply)*

If yes, please indicate level of severity:

Severity scale
1 = mild (does not interfere with daily activities) 2 = moderate (interferes with routine activities) 3 = severe (unable to perform routine activities)

	Symptoms experienced in the last week			Level of Severity (1, 2 or 3)	How many days did it last? (1 day or less = 1 day)
a.	Fever	No	Yes		
b.	Itching at vaccine site	No	Yes		
c.	Swelling at vaccine site	No	Yes		
d.	Pain at vaccine site	No	Yes		
e.	Red lines or streaks at vaccine site	No	Yes		
f.	Redness due to bandage tape/adhesive	No	Yes		
g.	Swollen or tender lymph nodes	No	Yes		
h.	Rash on any part of the body	No	Yes		
i.	Sores, blisters or lesions NOT at vaccine site	No	Yes		
j.	Eye or vision problems	No	Yes		

⇨⇨⇨ If yes, what was your highest temperature? _____

⇨⇨⇨ If yes to sores, where located? _____

Section C: Impact on Daily Life

7. Did you visit a doctor for conditions or symptoms related to your vaccination? No Yes

If yes, name of Doctor: _____ Doctor phone: _____

8. Did you take antibiotics for your symptoms? No Yes

If yes, name of antibiotic taken: _____

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Vaccinee Full Name: _____ **PVN:** _____

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9. Has <u>anyone else</u> in your house visited a doctor for conditions or symptoms related to YOUR vaccination? No Yes

If yes, name of person: _____ Name of Doctor: _____ Phone: _____

10. Did you miss any work due to conditions or symptoms related to your vaccination? No Yes

If yes, how many days did you miss? _____ *(if less than a full day, count as one day)*

11. Were you put on administrative restriction, or were your regular work duties changed, while you were recovering from your vaccination? No Yes

Section D: Contraindications to smallpox vaccination

12. Did you discover that you had any contraindications to vaccination <u>after</u> you received the smallpox vaccine? No Yes

If yes, please *check* all those that apply:		
	a.	Pregnancy at time of vaccination, or within 28 days after vaccination
	b.	Allergy to any component of the vaccine, including polymyxin B sulfate, dihydrostreptomycin sulfate, chloretetracycline hydrochloride, or neomycin sulfate
	c.	History of eczema, atopic dermatitis, or acute or chronic exfoliative skin conditions such as wounds, burns, impetigo, or recent Varicella zoster infection
	d.	Congenital or acquired immune system deficiencies
	e.	Immunosuppression due to underlying conditions such as: organ transplant, leukemia, lymphoma, lupus, diabetes, or other condition
	f.	Receiving therapy with systemic corticosteroids, immunosuppressive drugs, or radiation
	g.	Heart conditions such as: previous myocardial infarction (heart attack), angina (chest pain caused by lack of blood flow to the heart), congestive heart failure, cardiomyopathy, or other heart condition.
	h.	Other, please specify:

If you have questions regarding this form, please contact the KDHE Epidemiology Hotline (toll-free) at 1-877-427-7317.

Thank you for your cooperation!

Please return this form to the nurse or attendant before you leave.